#211 - Cancer rehabilitation services in Singapore: Implementation barriers and facilitators

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Objectives/aims
This study aims to explore the implementation facilitators and barriers of cancer rehabilitation services thus far in Singapore's public healthcare system. Understanding the current needs and experiences of patients could improve the implementation strategies to better match services to patients who require them.

Methods
One-hour semi-structured interviews were conducted with cancer patients. Open-ended questions were asked about their experiences, attitudes, and expectations of cancer rehabilitation services and views on integrating technology into cancer rehabilitation. To date, 8 interviews have been conducted (ages 41 – 56, 1 female) and transcribed verbatim. While data collection is ongoing, 4 have been analysed qualitatively using inductive thematic analysis.

Main findings
Preliminary data showed two broad classes of barriers and facilitators: individual-level factors and program-level factors. For individual barriers, patients not accessing rehabilitation fall under two categories: good and bad prognoses. As patients showed good progress or have sufficient resources in managing their condition, they would like to reserve the services for others in need. Conversely, patients with terminal prognoses perceived rehabilitation to be limited to the psychological and medical levels, without encompassing end-of-life care. Regarding program-level barriers, these included exposure to the program, program delivery, and the use of technology. Patients were aware of the availability of rehabilitation. However, they did not have a comprehensive understanding of the specific services offered and only knew of patient support groups. For program delivery, barriers such as lack of synergy of rehabilitation with treatments and language barriers were cited.
Regarding the use of technology in cancer rehabilitation, patients highlighted a preference for in-person interactions over digital ones, as the 'current technology may make people more superficial' and causes them to disengage from meaningful physical interactions, which they perceive to be more 'in-depth' and important.

Additionally, the older population may show resistance to technology adoption, increasing the barriers to implementing rehabilitation via technology.

For individual facilitators, patients had a positive attitude toward the availability of cancer rehabilitation. They cited reasons such as trusting the services provided by public healthcare; being able utilize the services for them and their families to cope with the diagnosis and treatment journey; and having prior pleasant experiences with some services (e.g., dietitian). As for program facilitators, patients wanted cancer rehabilitation to provide step-by-step guidance through their journey, from the initial diagnosis to subsequent treatment points in an all-rounded manner: physically, emotionally, and spiritually. Specifically, on physical support, patients preferred guides to physical exercises, food intake, managing their conditions, and the side effects of treatments. Patients have also cited the need to access emotional support such as peer support groups and professional counselling. Secondly, patients expressed a willingness to pay for the services used, but it should be subsidized according to their financial situation. The last program facilitator was areas where technology could be implemented. Although patients preferred the human element in their rehabilitation, they agreed that technology could be used to simplify aspects of cancer rehabilitation, such as providing personalised information and reminders on cancer conditions and recovery exercises.

In conclusion, the preliminary facilitators and barriers identified highlight areas to finetune the implementation strategies. This could include tapping on the positive attitude patients have or fulfilling their expectations of the services to better suit their needs, in terms of cost and delivery. Concurrently, the existing barriers to accessing rehabilitation could be lowered, through means such as targeted delivery of services to individuals who are in need, increasing exposure to the specific services offered, personalizing the rehabilitation around treatment, or implementation in multiple languages. In doing so, rehabilitative care could be provided in a continuum, personalized to treatment journeys.